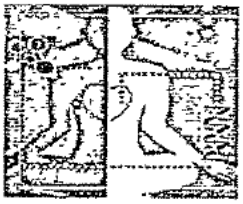
EXHIBIT F



RES PHYSICAL MEDICINE & REHAB SERVICES
Mikhail Strutsovskiy, MD
2470 WALDEN AVENUE SUITE 300
CHEEKTOWAGA, NY 14225 (716) 681-2968 FAX (716) 681-4240

Initial Evaluation

Name [redacted] **Date:** 04/20/2011
DOB: [redacted]
Claim #: 0160618690101089
Date of Loss: 01/12/2011
Referred by Dr. Scott Croce
History: Patient is a 55-year-old African American male presented today with c/o of cervical, left shoulder, left arm, right buttock left anterior leg, thoracic, and lumbar spine pain. Also, patient is c/o of severe headaches, numbness, tingling, muscle spasms in the right hand and fingers, and insomnia.
Patient was involved in a car accident on 01/12/2011. Patient was a restrained driver when his car was T-boned by another vehicle at the area quarter panel. Patient had pain right away. Patient was driven to Sister's Emergency Room by his friend. Patient was evaluated and released the same day. Patient was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. At present patient interested to enter the official pain management program.
Pain at present 7/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 6/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 10 min walking, standing or sitting aggravate pain
Pain is piercing, throbbing aching and sometimes lightning sharp-(-like pin sticking in the back) in nature
Pain is constant Variable in intensity
Patient tried Norco and Flexeril with some success and Ibuprofen 800mg -Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.
PMH: Car accident in 2005. Patient stated he had minimal deficits after this accident
PSH: Cervical spine surgery
Medications:

1. **Norco 7.5 over 325 one p.o. q. 4 hours p.r.n.**
2. **Flexeril 10 mg one p.o. q.8 hours p.r.n.**
3. **Ibuprofen 800 mg p.o. q.8 hrs**

Allergies: NKDA
Family History: Noncontributory
Social History:

Smoking: 1/2 a pack a day

ETOH use: none

Illicit drugs: none

Occupation Patient is currently not working, but prior to accident worked as a carpenter.

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	Minor GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, dizziness, short-term memory deficits, highly emotional.
Endocrinological:	No history of thyroid disease or diabetes,
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an African American male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 195/125, HR-111-120, RR-12, O2 sat 97% on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were irregular, tachycardic.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The Pt had rounded shoulders, hyperextended neck, and forward position of the head. Spurling tests (provocative

test for foraminal encroaching) was positive. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.

- The Pt demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 40 % in all planes. There were no bony misalignments and acute fractures but the Pt had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain. Positive extreme laxity noted throughout all joints.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The Pt has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above. No confusion, but the patient was very emotional during the interview. Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in upper extremities, except in the right upper extremity especially hand and wrist in the C6-7, C7-T1 dermatomes. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on 01/12/2011
2. Whiplash injury, cervical sprain/strain.
3. Cervical radiculopathy
4. Lumbar radiculopathy
5. Lumbar ligamentous strain
6. Cervical spine pain

7. Lumbar spine pain
8. Midthoracic sprain/strain.
9. Occipital neuralgia.
10. Cervicocranial Syndrome
11. Sacroiliitis
12. Soft tissue injury and Myofascial pain syndrome, trigger points, muscle guarding. Quebec Classification Grade II-III

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

No related to automobile accident:

1. Atrial fibrillation with rapid ventricular response

2. Hypertensive crisis

Plan:

Medications:

I will continue patient on:

1. Norco 10/325 one p.o. q.6 hours p.r.n. none prescribed today
2. Flexeril 10 mg one p.o. q.8 hours p.r.n. #45 prescribed

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient stated he would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient. Opioid risk tool questionnaire was administered. Score was 2/10. Patient is low risk for opioid addiction
Baseline urine toxicology screen was obtained from the patient. Please see table below for results:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates		X	Consistent
4. Amphetamines	X		Consistent
5. Phencyclidine	X		Consistent

6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone		X	Artifact-Consistent
Data collection	04/20/2011		

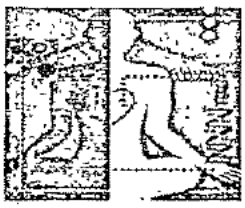
Urine toxicology screen was discussed the patient. It is consistent with medication regimen prescribed. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program. I advise patient after the appointment to check in to emergency room for atrial fibrillation with rapid ventricular response and hypertensive emergency. I advised patient not to drive to the hospital but rather be either driven by somebody or I can call ambulance. Patient refused ambulance and stated his wife will bring him to Sister's Hospital Emergency Room. Patient is rescheduled for follow-up in 2 weeks

Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 60 minutes with the patient. CPT code for this encounter is 99244 and CPT code for urine toxicology screen is 80101 x9 units please use modifier QW. Please charge in accordance with New York state fee schedule.

Date: 04/20/2011

Mikhail Strutsovskiy M.D.

CC:



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Initial Evaluation

Name: [redacted]
DOB: [redacted]
Claim #: 2011008180-5
Date of Loss: 08/31/2011

Date: 09/01/2011

History: Patient is a 27-year-old African American male presented today with c/o of cervical, thoracic, and lumbar spine pain. Also, patient is c/o of intermittent headaches and insomnia. Patient was involved in a car accident on 08/31/2011. Patient was a restrained driver when his car was rear-ended by another car. Patient had stiffness right away. Today, patient woke up with severe pain. Patient seeks medical care. He presented today to my office for initial evaluation.
Pain at present 7/10 on Visual Analog Scale
At worst it is 9/10 on Visual Analog Scale
At best pain is 6/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 15 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity
Patient tried Ibuprofen 200 mg 4 tablets p.o. q.8 hours with mild to no success.
PMH: Left shoulder gunshot wound. No residual deficits after this incident.
PSH: Left shoulder gunshot wound repair
Medications:

1. Ibuprofen 800 mg p.o. q.8 hrs

Allergies: NKDA
Family History: Noncontributory
Social History:

Smoking: none
ETOH use: 2-3 drinks on weekend
Illicit drugs: none
Occupation Patient is currently works us in direct support assistant in assisted-living facility. His job requires patient to lift heavy up to 200 pounds.

REVIEW OF SYSTEM:

General:	No Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	No GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, somewhere emotional.
Endocrinological:	No history of thyroid disease or diabetes.

Hematological: Denies anemia. No lymphadenopathy.
Skin: No rash, edema, or dystrophic changes.
Vascular: No evidence of vascular disease.
** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:
General: The patient is an African American male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs: Stable. BP: 110/84, HR-83, RR-14, O2 sat 97% on room air.
HEENT: No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck: Neck was supple. Free of scars and lymphadenopathy.
Chest: Clear to auscultation, no wheezing, and no rales.
CVS: Heart sounds were regular, S1-S2, no murmur. No rub. No gallop.
Abdomen: Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Musculoskeletal: No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated good body mechanics with slightly hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The patient had hyperextended neck. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid. bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.
- The patient demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 35 % in all planes. There were no bony misalignments and acute fractures but the patient had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The patient has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in bilateral upper and lower extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on 08/31/2011
2. Whiplash injury, cervical sprain/strain.
3. Cervical radiculopathy
4. Lumbar radiculopathy
5. Lumbar ligamentous strain
6. Cervical spine pain

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

Plan:

Medications:

I will start patient on:

1. Tramadol 50 mg one p.o. q.6 hour p.r.n. #45 prescribed
2. Flexeril 5 mg one p.o. q.8 hour p.r.n. #45 prescribed
3. Voltaren 75 mg one p.o. q.12 hours 30 prescribed
4. Bio-Freeze apply to affected area q.6 hour p.r.n. #1 tube prescribed the 5 refills

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and none Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient. Risk Assessment Tool Questionnaire was administered. Score was 1/10. Patient is very low risk to develop opiate dependence/addiction. I will refer patient for chiropractic care. It is in my professional opinion chiropractic care will benefit patient the most at present. I will advise patient to attend chiropractic care 3 times a week for next 12 weeks. I also will obtain x-rays of cervical and lumbar spine to evaluate for possible fracture.
Baseline urine toxicology screen was obtained from the patient. Please see table below for preliminary results:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent
5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	09/01/2011		

Urine toxicology screen was discussed the patient. It is consistent with medication regimen prescribed. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program.
Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 60 minutes with the patient. CPT code for this encounter is 99244 and CPT code for urine toxicology screen is 80101 x9 units Please process in accordance with New York state fee schedule.

Date: 09/01/2011

Mikhail Strutsovskiy M.D.

CC: Timothy Andrushat Esq.

We apologize for any typographical errors in our documentation. We use voice recognition software to assist us and errors may be missed in the editing process.

Mikhail Strutsovskiy M.D.
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716-681-2968
Fax# 716-681-2969
NPI# 1699970491
TIN# 061657957

Initial Evaluation

Name: [redacted]
DOB: [redacted]
Date: 12/28/2010
Claim #: 0337718910101154
Date of Loss: 12/14/2010
Referred: by Dr Hagen

History: Patient is a 28 year-old white male presented today with c/o cervical, right shoulder, thoracic, and lumbar spine pain. Also, he is c/o of severe headaches and mild insomnia.

Patient was involved in a car accident on December 14, 2010. Patient was a restrained driver when he is car was rear-ended by another car. Patient had pain right away. He drove himself to Meta First Urgent Care Center. He was evaluated and released the same day. He was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. At present, patient interested in entering official pain management program.

Pain at present 5/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 4/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 10 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity
Patient tried Lortab and Flexeril with moderate success, and Ibuprofen 800mg-Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.

PMH: None
PSH: None.
Medications:

1. Ibuprofen 800 mg p.o. q.8 hrs
2. Tylenol thousand milligrams p.o. q.8 hours.interchangeable with ibuprofen
3. Flexeril 10 mg one p.o. q.8 hours p.r.n.

Allergies: NKDA
Family History: Noncontributory
Social History:

- Smoking: none

  ETOH use: Once a month

Illicit drugs: Marijuana for pain last use was one week ago.

Occupation Patient is currently not working, but prior to accident worked Technical Support clerk.

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	Minor GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, highly emotional.
Endocrinological:	No history of thyroid disease or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is white male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 134/84, HR-76, RR-14, O2 sat 97% on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were regular, S1-S2, no murmur. No rub. No gallop.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The Pt had rounded shoulders, hyperextended neck, and forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area

was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.

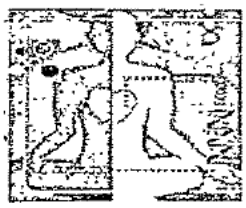
- The Pt demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 25 % in all planes. There were no bony misalignments and acute fractures but the Pt had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The Pt has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above. No confusion, but the patient was very emotional during the interview. Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in upper extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on December 14, 2010
2. Whiplash injury, cervical sprain/strain.
3. Cervical pain
4. Cervical radiculopathy.
5. Low back pain
6. Midthoracic sprain/strain.
7. Occipital neuralgia.
8. Lumbar strain/sprain



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Initial Evaluation

Name: [redacted] **Date:** 05/11/2011
DOB: [redacted]
Claim #: 0336642700101037
Date of Loss: 04/07/2011
Referred by Dr. Scott Croce

History: Patient is a 33-year-old Arabic male presented today with c/o of cervical, left hip, left thigh thoracic, and lumbar spine pain. Also, patient is c/o of severe headaches, bilateral lower extremity paresthesia left much more involved than right and insomnia. Patient was involved in a car accident on 04/07/2011. Patient was a restrained driver when his car was T-boned by another car. Patient admits to temporary loss of consciousness. Positive transient post accident amnesia. Patient had pain right away. Patient was taken to ECMC Hospital emergency room by his brother on the next day. Patient was evaluated and released the same day. Patient was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. Patient seeks chiropractic care and other pain management modalities. At present, patient interested in entering official pain management program.
Pain at present 7/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 6/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 5 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity
Patient tried Ibuprofen 800mg -Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.
PMH: None
PSH: Appendectomy in 1998
Medications:

1. Ibuprofen 800 mg p.o. q.8 hrs

Allergies: NKDA
Family History: Noncontributory
Social History:

Smoking: 4 cigarettes a day

ETOH use: none

Illicit drugs: none

Occupation Patient is currently not working, but prior to accident worked as grocery store owner/operator.

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	Positive SOB, however, denies cough or asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	Minor GI discomfort after taking COX I inhibitors. Positive constipation.
Genito-Urinary:	Positive urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, highly emotional.
Endocrinological:	No history of thyroid disease or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an Arabic male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 123/88, HR-74, RR-14, O2 sat 97% on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were regular, S1-S2, positive mid-systolic murmur.

No rub. No gallop.

Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. Positive dystrophic changes of skin on the foot noted over left foot and ankle. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The Pt had rounded shoulders, hyperextended neck, and

forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.

- The Pt demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 25 % in all planes. There were no bony misalignments and acute fractures but the Pt had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The Pt has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above. No confusion, but the patient was very emotional during the interview. Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in bilateral upper and lower extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on October 1, 2010
2. Whiplash injury, cervical sprain/strain.
3. Cervical radiculopathy
4. Lumbar radiculopathy
5. Lumbar ligamentous strain
6. Cervical spine pain
7. Lumbar spine pain

8. Midthoracic sprain/strain.
9. Occipital neuralgia.
10. Cervicocranial Syndrome
11. Sacroiliitis
12. Posttraumatic stress disorder
13. Anxiety
14. Depression
15. Soft tissue injury and Myofascial pain syndrome, trigger points, muscle guarding. Quebec Classification Grade II-III

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

Plan:

Medications:

I will start patient on:

1. Tramadol 50 mg one p.o. q.6 hour p.r.n. #60 prescribed
2. Amitriptyline 25 mg one p.o. q.h.s. #15 prescribed for sleep and headaches
3. Xanax 0.25 mg one p.o. q.8 hour p.r.n. #45 prescribed for anxiety and posterior mitral disorder

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient. Risk Assessment Tool Questionnaire was administered. Score was 1/10. Patient has low risk to develop opioid dependence/addiction
Baseline urine toxicology screen was obtained from the patient. Please see table below for preliminary results:

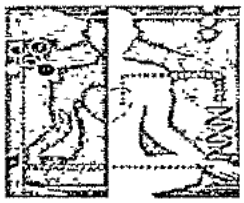
Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent

5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	05/11/2011		

Urine toxicology screen was discussed the patient. It is consistent with medication regimen prescribed. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program.
MRI of the lumbar spine and cervical spine reviewed. A lumbar MRI strengthening of lumbar lordosis with L5-S1 mild disc bulge noted. Normal cervical spine MRI was observed. I will await own official report from radiologist.
Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 60 minutes with the patient. CPT code for this encounter is 99244 and CPT code for urine toxicology screen is 80101 x9 units please use modifier QW. Please charge in accordance with New York state fee schedule.

Mikhail Strutsovskiy M.D. **Date: 05/11/2011**

CC:



RES PHYSICAL MEDICINE & REHAB SERVICES
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Initial Evaluation

Name: [redacted] **Date:** 02/22/2011
DOB: [redacted]
Claim #: 0385474920101039
Date of Loss: 01/14/2011

History: Patient is a 25-year-old African American male presented today with c/o of cervical, bilateral legs, thoracic, and lumbar spine pain. Also, patient is c/o of severe headaches and insomnia.
Patient was involved in a car accident on 01/14/2011. Patient was a restrained driver when his car was T-boned by a truck. Patient admits into loss of consciousness. Admits to post accident amnesia. He also complains of short-term memory deficits. Patient did not remember if he had pain right away. Patient was taken to ECMC by ambulance. Patient was evaluated and released the same day. Patient was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. At present, patient interested in entering official pain management program.
Pain at present 10/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 5/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 20 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity
Patient tried Ibuprofen 800mg -Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.
PMH: Fracture of right femur, fracture of the nose
PSH: Surgical repair of right femur in 2005, nose surgery at younger age.
Medications:
1. None

Allergies: NKDA
Family History: Noncontributory
Social History:

Smoking: 4 cigarettes per day

ETOH use: One to 2 drinks a week

Illicit drugs: none

Occupation Patient is currently not working, but prior to accident worked as a tire technician at Done tire.

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	No GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, highly emotional.
Endocrinological:	No history of thyroid disease or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an African American male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 134/84, HR-81, RR-14, O2 sat fluctuated between 87 and 98% on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were regular, S1-S2, positive S3 sounds heard. Positive holosystolic murmur. Positive gallop.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The Pt had rounded shoulders, hyperextended neck, and forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area

was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.

- The Pt demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 25 % in all planes. There were no bony misalignments and acute fractures but the Pt had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The Pt has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above. No confusion, but the patient was very emotional during the interview. Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in upper extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on 01/14/2011
2. Whiplash injury, cervical sprain/strain.
3. Cervical radiculopathy
4. Lumbar radiculopathy
5. Lumbar ligamentous strain
6. Cervical spine pain
7. Lumbar spine pain
8. Midthoracic sprain/strain.

9. Occipital neuralgia.
10. Cervicocranial Syndrome
11. Sacroiliitis
12. Traumatic brain injury
13. Diffuse axonal injury
14. Short-term memory deficits
15. Soft tissue injury and Myofascial pain syndrome, trigger points, muscle guarding. Quebec Classification Grade II-III

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

1. **Cardiac abnormalities**
2. **Possible congenital or hypertensive cardiac hypertrophy**
3. **Aortic valve abnormality due to congenital hypertrophy of the cardiac muscle**

The diagnosis are not related to car accident, however, we are serious enough to deserve investigation and referral to cardiologist. I advise patient on importance of taking care of this problem because it might be life-threatening if left unattended. It'll also impair my ability to perform interventional procedures because of unknown cardiac status of the patient.

Recommendations:

1. Musculoskeletal ultrasound
2. NCS/EMG to rule out or confirm radiculopathy.
3. Steroid epidural injections for pain and inflammation control.
4. Trigger point injections using 1% Lidocaine.
5. Neurotherapy/chemodenervation of paraspinal muscles using Botox/Phenol/Ethanol.
6. Facet joint, tendon sheath and bony-tendinous attachment injections (Prolotherapy).
7. Myofascial release, massage, acupuncture.
8. Gait training, assistive devices evaluation.

9. Prosthetics/orthotics, medial arch supportive braces for both feet, lumbo-sacral brace for trunk support, adaptive equipment as needed.

10. Mood stabilization, trail of SSRI. Psychiatry/psychology consults.

11. Pain – trial of Narcotic Medications with consequent recovery program post completion of treatment.

12. Pain cream 10% gabapentin, 10% ketoprofen, 10% ketamine for topical relief and prevention of controlled substance diversion.

13. Physical modalities (phonophoresis, iontophoresis, US, diathermy in subacute cases). TENS.

14. Nutrition, natural ergogenic aids for pain control (chondroitin, glucosamine, /MSM).

15. Treat comorbid conditions- as per PMD

Plan:

Medications:

I will start patient on:

1. Tramadol 50 mg one p.o. q. 6 hour p.r.n.
2. Flexeril 10 mg one p.o. q.8 hours p.r.n.

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient stated she would like to review the handout at home and then make a decision. Patient was extensively counseled.
Patient's MRI is reviewed by me and L4-L5 disc herniation with compression of L4 nerve root noted.
Also The Opioid Pain Management Agreement was signed by the Patient.
Baseline urine toxicology screen was obtained from the patient. Please see table below for results:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent

5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	02/22/2011		

Urine toxicology screen was discussed the patient. It is consistent with medication regimen prescribed. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program.

Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 80 minutes with the patient. CPT code for this encounter is 99245 and CPT code for urine toxicology screen is 80101 x9 units please use modifier QW. Please charge in accordance with New York state fee schedule.

Mikhail Strutsovskiy M.D.

Date: 02/22/2011

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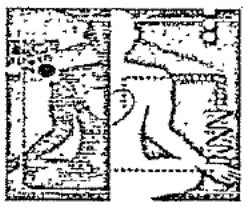

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Initial Evaluation

Name: [redacted] Date: 08/31/2011
DOB: [redacted]
Claim #: 0134850100101101
Date of Loss: 08/22/2011
Referred by Dr. John Ward

History: Patient is a 49-year-old African American female presented today with c/o of cervical, left shoulder, left arm, thoracic, and lumbar spine pain. Also, patient is c/o of severe headaches and insomnia.
Patient was involved in a car accident on 08/22/2011. Patient was a restrained driver when car was involved in automobile accident. Patient admits to loss of consciousness. Patient drove to Millard Fillmore Suburban Hospital emergency room. Patient was evaluated and released the same day. Patient was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. Patient seeks chiropractic care and other pain management modalities. At present, patient interested in entering official pain management program.
Pain at present 8/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 7/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 10 min walking; standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity
Patient tried Lortab with moderate success, and Ibuprofen 600mg -Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.
PMH: Hypertension, COPD, Goiter.
PSH: Hysterectomy 12 years ago left ankle fracture without need for surgical repair 30 years ago.
Medications:

1. Ibuprofen 800 mg p.o. q.8 hrs
2. Tylenol thousand milligrams p.o. q.8 hours interchangeable with ibuprofen

Allergies: NKDA
Family History: Noncontributory
Social History:
Smoking: 10 cigarettes a day
ETOH use: 2 -3 drinks per week
Illicit drugs: none
Occupation Patient is currently not working, but prior to accident worked as a CNA

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	Positive for SOB and COPD.

Cardiovascular:	No CAD, cardiac arrhythmias, positive for HTN.
Gastrointestinal:	No GI discomfort after taking COX I inhibitors. Negative for diarrhea or constipation
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low Back pain.
Neurological:	Headaches, insomnia, short-term memory deficits, highly emotional.
Endocrinological:	Positive for history of thyroid disease (goiter) or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an African American female who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 124/64, HR-71, RR-14, O2 sat 96% on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales.
CVS:	Heart sounds were regular, S1-S2, no murmur. No rub. No gallop.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The patient had rounded shoulders, hyperextended neck, and forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.
- The patient demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 25 % in all planes. There were no bony misalignments and acute fractures but the patient had difficulty with squatting and

toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The patient has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in bilateral upper and lower extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on 8/22/11
2. Whiplash injury, cervical sprain/strain.
3. Cervical radiculopathy
4. Lumbar radiculopathy
5. Lumbar ligamentous strain
6. Cervical spine pain

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

Plan:

Medications:

I will start patient on:

1. Lortab 5/500 one p.o. q.6 hours p.r.n. #30 prescribed
2. Flexeril 5 mg one p.o. q.8 hours p.r.n. #45 prescribed
3. Motrin 600 mg one p.o. q.8 hours p.r.n. #45 prescribed

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient. Risk Assessment Tool Questionnaire was administered. Score was 0/10. Patient has low risk to develop opiate addiction/dependence.

Baseline urine toxicology screen was obtained from the patient. Please see table below for preliminary results:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent
5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	08/31/2011		

Urine toxicology screen was discussed the patient. It is consistent with medication regimen prescribed. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program.

Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 60 minutes with the patient. CPT code for this encounter is 99244 and CPT code for urine toxicology screen is 80101 x9 units Please process in accordance with New York state fee schedule.

MD

Date: 08/31/2011

Mikhail Strutsovskiy M.D.

CC: Dr. John Ward

We apologize for any typographical errors in our documentation. We use voice recognition software to assist us and errors may be missed in the editing process.

Mikhail Strutsovskiy M.D.
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716-681-2968
Fax# 716-681-2969
NPI# 1699970491
TIN# 061657957

Initial Evaluation

Name: [redacted] Date: 01/12/2011
DOB: [redacted]
Claim #: 0322227410101026
Date of Loss: 09/27/2009
Referred by Dr. Croce

History: Patient is a 31-year-old African American male presented today with c/o of cervical, right shoulder, right lower extremity, thoracic, and lumbar spine pain. Also, he is c/o of headaches and insomnia.

Patient was involved in a car accident on September 27, 2009. Patient was a restrained driver when car was rear-ended by dump truck. Patient developed stiffness right away. Next morning patient developed severe pain and was taken by his friend to ECMC Emergency Room. Patient was evaluated and released the same day. Patient was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. At present, patient interested in entering official pain management program. Patient is a doctor Bernard Boupin who discharged patient from his pain management program for few missing appointments.

Pain at present 8/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 7/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 5 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity
Patient tried Lortab and Darvocet with moderate success, and Ibuprofen 800mg -Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.
PMH: Asthma
PSH: Right knee arthroscopy
Medications:

1. Ibuprofen 800 mg p.o. q.8 hrs
2. Tylenol thousand milligrams p.o. q.8 hours interchangeable with ibuprofen

Allergies: NKDA
Family History: Noncontributory
Social History:

Smoking: none

ETOH use: 5 years in attempts

Illicit drugs: none

Occupation Patient is currently not working, but prior to accident worked as a juvenile detention center behavior management specialist. His job required physical fitness and ability to lift what the patient does not have at present.

REVIEW OF SYSTEM:

General:	No Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	Minor GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, highly emotional.
Endocrinological:	No history of thyroid disease or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an African American female who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 136/90, HR-74, RR-14, O2 sat 99 % on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 6 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were regular, S1-S2, no murmur. No rub. No gallop.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The Pt had rounded shoulders, hyperextended neck, and

forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally. Also positive pain on palpation noted over right lunate. Excessive anterior translation of lunate is also detected. Positive pain on palpation noted over triangle fiber cartilage on the right. Thess findings are consistent with TFCC sprain/strain which might be responsible for carpal tunnel syndrome. Tinel sign is negative on the right wrist.

- The Pt demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 25 % in all planes. There were no bony misalignments and acute fractures but the Pt had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The Pt has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological:

Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above. No confusion, but the patient was very emotional during the interview. Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in upper extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on September 27, 2009
2. Whiplash injury, cervical sprain/strain.
3. Right shoulder pain

4. Right lower extremity pain
5. Cervical pain
6. Cervical radiculopathy.
7. Low back pain
8. Midthoracic sprain/strain.
9. Occipital neuralgia.
10. Lumbar strain/sprain
11. Cervicocranial Syndrome
12. Sacrciliitis
13. Soft tissue injury and Myofascial pain syndrome, trigger points, muscle guarding. Quebec Classification Grade II-III
14. Post-traumatic stress disorder. Adjustment disorder.
15. Lumbar Disc Displacement without Mylopathy

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

Recommendations:

1. Musculoskeletal ultrasound
2. NCS/EMG to rule out or confirm radiculopathy.
3. Steroid epidural injections for pain and inflammation control.
4. Trigger point injections using 1% Lidocaine.
5. Neurotherapy/chemodenervation of paraspinal muscles using Botox/Phenol/Ethanol.
6. Facet joint, tendon sheath and bony-tendinous attachment injections (Prolotherapy).
7. Myofascial release, massage, acupuncture.
8. Gait training, assistive devices evaluation.
9. Prosthetics/orthotics, medial arch supportive braces for both feet, lumbo-sacral brace for trunk support, adaptive equipment as needed.
10. Mood stabilization, trail of SSRI. Psychiatry/psychology consults.

11. Pain – trial of Narcotic Medications with consequent recovery program post completion of treatment.

12. Pain cream 10% gabapentin, 10% ketoprofen, 10% ketamine for topical relief and prevention of controlled substance diversion.

13. Physical modalities (phonophoresis, iontophoresis, US, diathermy in subacute cases). TENS.

14. Nutrition, natural ergogenic aids for pain control (chondroitin, glucosamine, /MSM).

15. Treat comorbid conditions- as per PMD

Plan:

Medications:

I will start patient on:

1. Lortab 7.5/500 one p.o. q.6 hours p.r.n. #60 prescribed
2. Flexeril 10 mg one p.o. q.8 hours p.r.n. #45 prescribed

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and Narcotic Pain Management regimen will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient stated she would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient.
Baseline urine toxicology screen was obtained from the patient. Please see table below for results:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent
5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent

8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	01/12/2011		

Urine toxicology screen was discussed the patient. It is consistent with medication regimen prescribed. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program.

Patient informed me what tomorrow he is scheduled for carpal tunnel release on the right upper extremity. Due to the nature of my findings ultrasound of right carpal tunnel was proposed to the patient in order to confirm size of the nerve and evaluate if median nerve affected to the degree which required surgical release. Patient agreed to proceed with musculoskeletal ultrasound of the right wrist.

Static real-time views in longitudinal and transverse orientation were obtained of this 31-year-old male. An acoustic stand-off was not utilized.

Palmar images demonstrated normal, intact flexor tendons with no synovitis. On short axis the median nerve measures 7.8 mm. Normal range for male/female is 7-9 mm. Comparative imaging of the contralateral median nerve produces across section area of 8.4 mm. A longitudinal view, the median nerve was noted to play collect, and large or fusiform proximal to the flexor retinaculum, and entrance into the carpal tunnel.

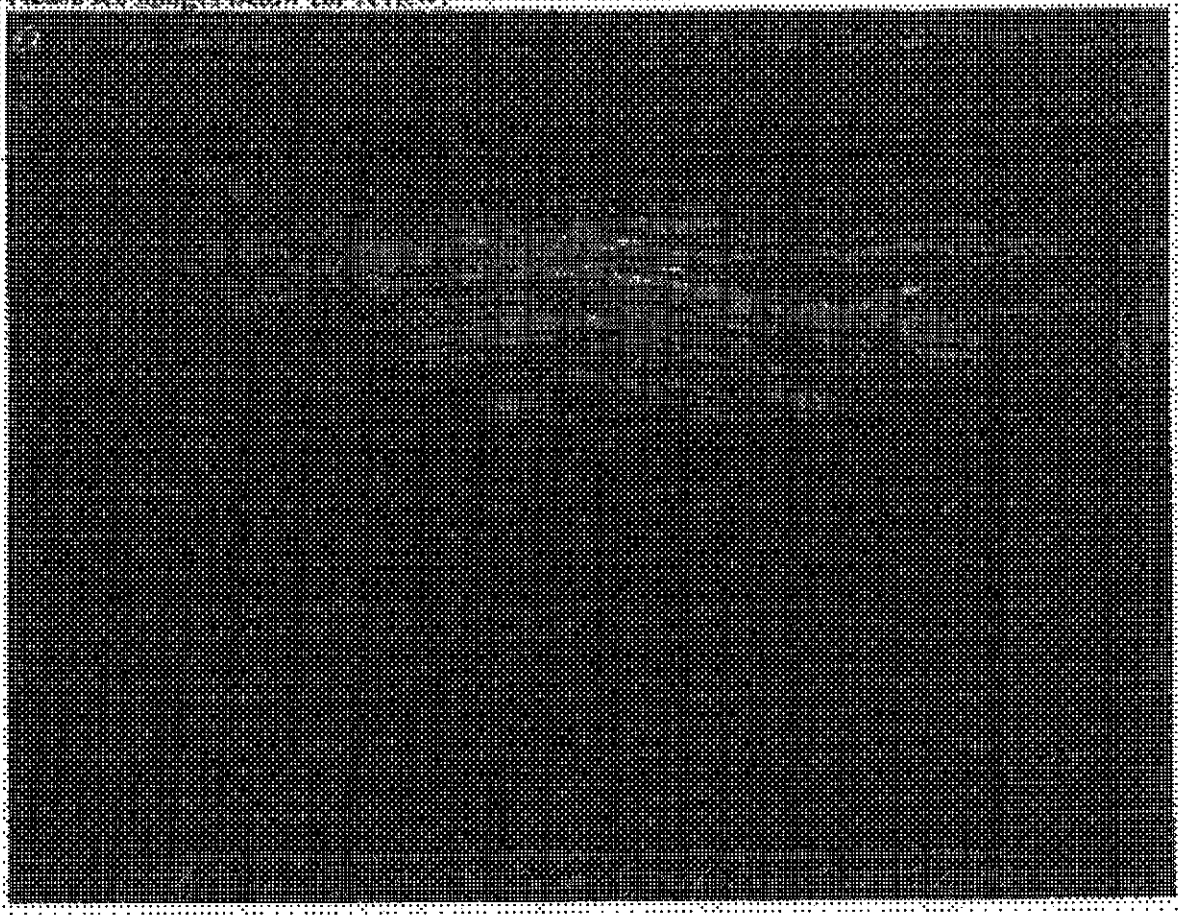
Dorsal images demonstrated extensive tendons and individual compartments with normal arm are due to inflammation. They are intact on long axis. No ganglion cyst is visualized. The dorsal aspect of the first metacarpal joint in long axis reveals normal extensor pollicis tendons. Proximal to the extensor retinaculum, the extensor pollicus brevis and abductor pollicus longus are not edematous as seen in the De Quervain's tenosynovitis. More distally, and on the ulnar aspect, of the first MPJ, the ulnar collateral ligament is intact. The cortical outline in the joint is well maintained. No evidence of hyper abduction injury. The Ulnar aspect of the dorsal increase the triangular fiber cartilage demonstrates increased echogenicity the evidence of tearing.

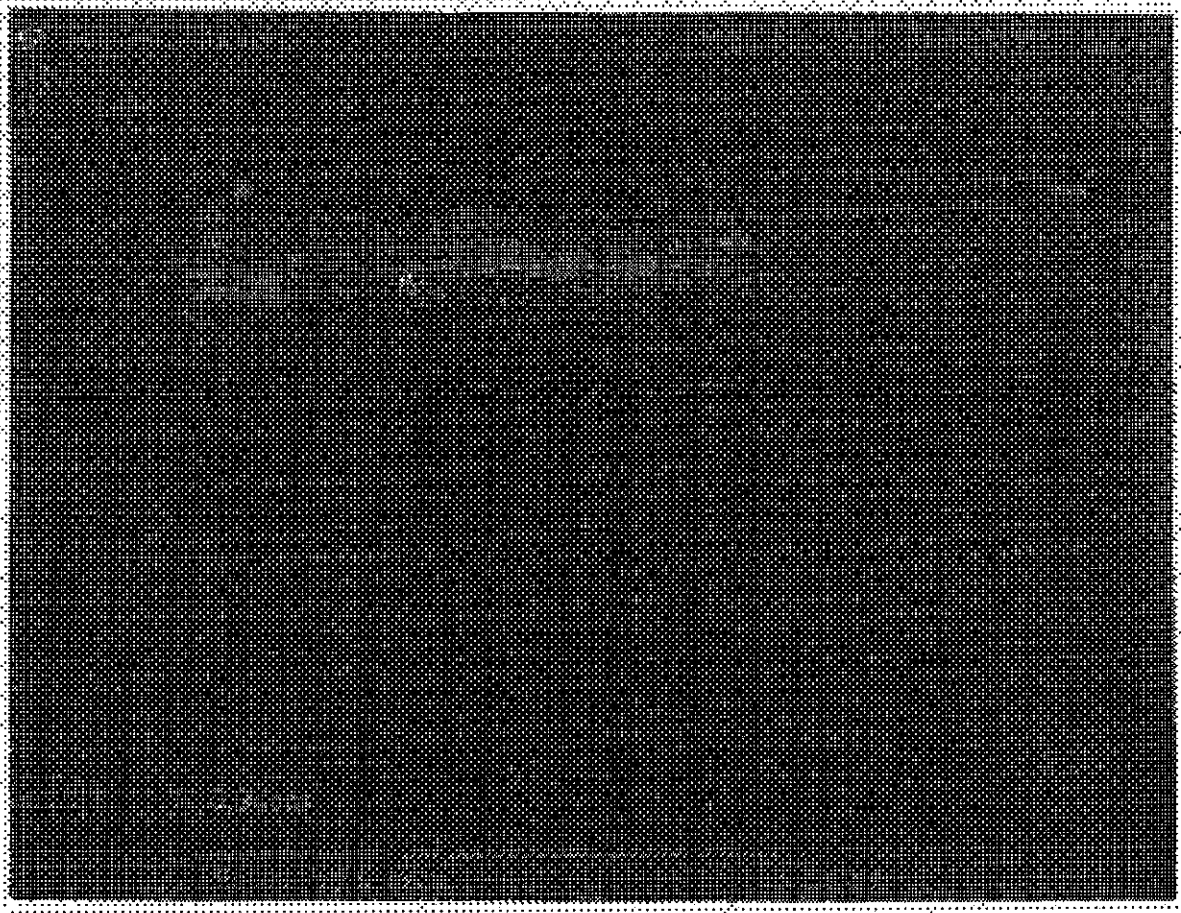
Images of metacarpo-phalangeal joints dorsal and palmar demonstrate no cortical irregularity or distraction. Synovial fluid and/or hypertrophy are not noted on the joint margins. Doppler signal to dental by synovial hypertrophy was not seen. No A1 pulley hypertrophy or abnormality as seen with trigger finger.

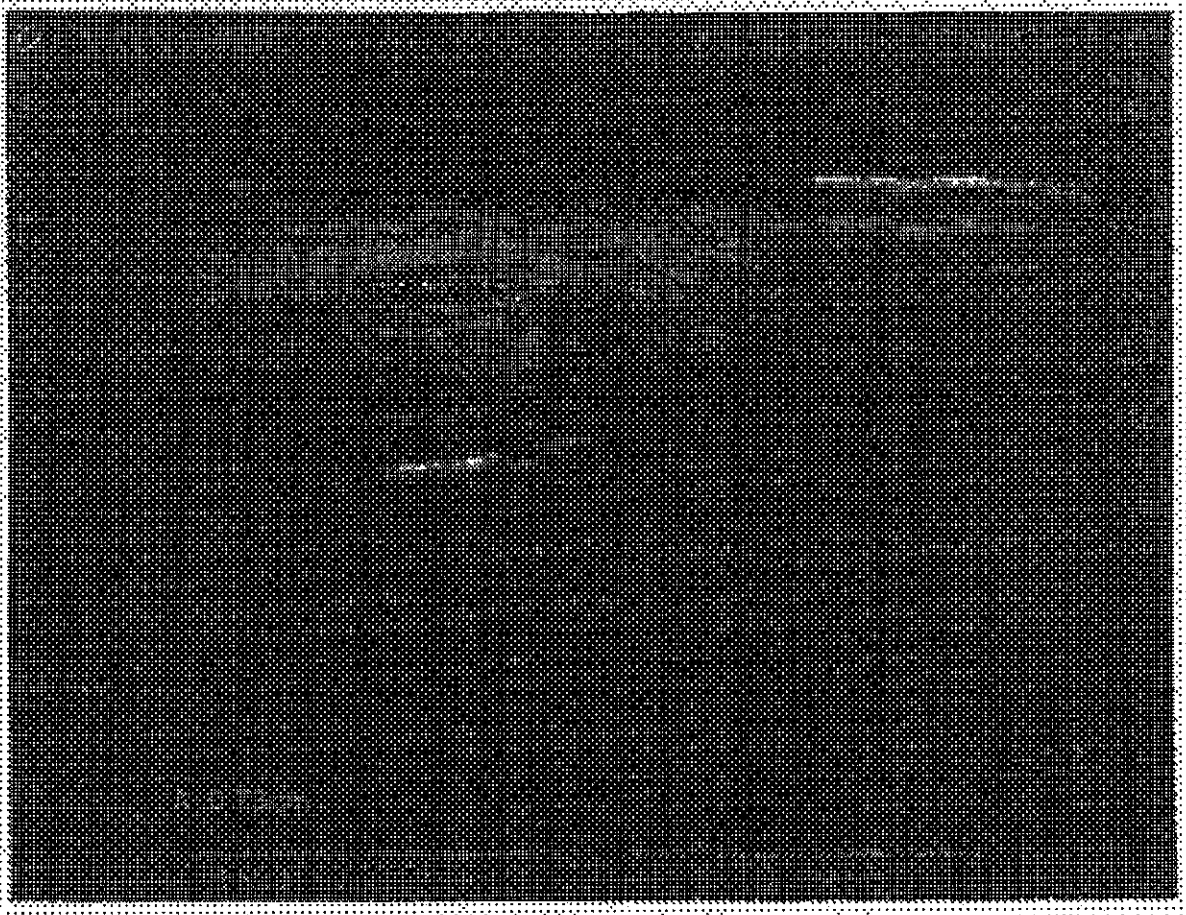
On dynamic image of the dorsal wrist in flexion/extension excessive anterior translation of the lunate noted with flattening of the median nerve to the abnormal range. This is suggestive of small intra-ligamentous disruption of the wrist complex producing hypermobile and excessive motion of lunate each can generate symptoms of the carpal tunnel.

I would like to review patient's electromyography-nerve conduction study results. In my professional opinion carpal tunnel release on the right wrist might be unnecessary, because it actually may cause exacerbation of her symptoms due to increase hypermobility of lunate. Trial of conservative measures such as intra-ligamentous injections may be performed. If this measure fails and patient still continued to have symptoms surgery may be warranted.

Please see images below for review:







Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 60 minutes with the patient. CPT code for this encounter is 99243. CPT code for musculoskeletal ultrasound of the bilateral wrists nonvascular is 76880 and CPT code for urine toxicology screen is 80101 x 9 units please use modifier QW. Please charge in accordance with New York state fee schedule.

Mikhail Stanisovskiy M.D.

Date: 01/12/2011

CC:

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Initial Evaluation

Name: [redacted] **Date:** 10/13/10
DOB: [redacted]
Claim #: 0329869100101023
Date of Loss: 09-01-2010

History: Patient is a 46-year-old African American male presented today with c/o cervical, left shoulder, left wrist, thoracic, and lumbar spine pain. Also he's c/o severe Headaches and insomnia.
Patient was involved in a car accident on September 1, 2010. Patient was a restrained driver when his car was rear-ended by another car. Patient had stiffness right away. In about 2 days he developed severe pain. He drove himself to Buffalo general Hospital emergency room. He was evaluated and released the same day. He was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. At present, patient interested in entering official pain management program.
Pain at present 8/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 7/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 5 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in Intensity
Patient tried Lortab 7.5, Flexeril 10 and tramadol provided him moderate relief, Ibuprofen 800mg -Tylenol 1000mg q4-5 hrs interchangeably with minor to no relief of pain.
PMH: None
PSH: None
Medications:

1. Lortab 7.5 over 500 mg p.o. q.6 hours p.r.n.
2. Tramadol 50 mg p.o. q. 8 hours p.r.n.
3. Flexeril 10 mg p.o. q.8 hours p.r.n.
4. Ibuprofen 800 mg p.o. q.8 hours
5. Tylenol thousand milligrams p.o. q.8 hours interchangeable with Ibuprofen

Allergies: None
Family History: Noncontributory
Social History:

Smoking: None

ETOH use: One drink a month

Illicit drugs: none

Occupation Patient is currently not working, but prior to accident was unemployed

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.
Gastrointestinal:	No GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, highly emotional.
Endocriniological:	No history of thyroid disease or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an African American male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 134/84, HR-76, RR-14, O2 sat 97% on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were regular, S1-S2, no murmur. No rub. No gallop.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged. Several scars from previous exploratory surgeries were noted.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.

- The Pt had rounded shoulders, hyperextended neck, and forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive without radiation to the right side. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius left much more involved than the right. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.
- The Pt demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 25 % in all planes. There were no bony misalignments and acute fractures but the Pt had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The Pt has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal, but mildly diminished in the left arm.

Neurological:

Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above. No confusion, but the patient was very emotional during the interview. Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in upper extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on September 1, 2010
2. Whiplash injury, cervical sprain/strain.
3. Cervical pain
4. Cervical radiculopathy.
5. Left shoulder pain
6. Left wrist pain

7. Low back pain
8. Midthoracic sprain/strain.
9. Occipital neuralgia.
10. Lumbar strain/sprain
11. Cervicocranial Syndrome
12. Sacroiliitis
13. Soft tissue injury and Myofascial pain syndrome, trigger points, muscle guarding.
14. Post-traumatic stress disorder. Adjustment disorder.
15. Functional deficit secondary to above.
16. Lumbar Disc Displacement without Mylopathy

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

Recommendations:

1. Musculoskeletal ultrasound
2. NCS/EMG to rule out or confirm radiculopathy.
3. Steroid epidural injections for pain and inflammation control.
4. Trigger point injections using 1% Lidocaine.
5. Neurotherapy/chemodenervation of paraspinal muscles using Botox/Phenol/Ethanol.
6. Facet joint, tendon sheath and bony-tendinous attachment injections (Prolotherapy).
7. Myofascial release, massage, acupuncture.
8. Gait training, assistive devices evaluation.
9. Prosthetics/orthotics, medial arch supportive braces for both feet, lumbo-sacral brace for trunk support, adaptive equipment as needed.
10. Mood stabilization, trail of SSRI. Psychiatry/psychology consults.
11. Pain – trial of Narcotic Medications with consequent recovery program post completion of treatment.

12. Pain cream 10% gabapentin, 10% ketoprofen, 10% ketamine for topical relief and prevention of controlled substance diversion.

13. Physical modalities (phonophoresis, iontophoresis, US, diathermy in subacute cases). TENS.

14. Nutrition, natural ergogenic aids for pain control (chondroitin, glucosamine, /MSM).

15. Treat comorbid conditions- as per PMD

Plan:

Medications:

I will start patient on:

1. Lortab 10/500 one p.o. q.6 hours
2. Skelexin 800 mg one p.o. q.8 hours p.r.n.

I discussed at length with the patient different strategies on how to manage her pain and a trial of Subosipital Nerve block, Facet Blocks, prolotherapy and Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on prolotherapy. I also counseled patient on statistics, indications, and contraindications of prolotherapy. Patient stated she would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient.
Baseline urine toxicology screen was performed. Please see results in table below:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent
2. Marijuana	X		Consistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent
5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent

11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	10-13-10		

Patient stated he will several days this out Lortab this is why hydrocodone does not appear in urine toxicology screen.

Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 80 minutes with the patient. CPT code for this encounter is 99245 and CPT code for urine toxicology screen 80101 x9 units please use modifier QW. Please charge in accordance with New York state fee schedule.

Date: 10 - 13-2010

Mikhail Strutsovskiy M.D.

CC:

RES PHYSICAL MEDICINE & REHAB SERVICES
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2470 WALDEN AVENUE SUITE 300
CHEEKTOWAGA, NY 14225 (716) 681-4088 FAX (716) 681-4240

Initial Evaluation

Name [redacted] Date: 07/14/2011
DOB: [redacted]
Claim #: 052635030300101058
Date of Loss: 09/25/2010

History: Patient is a 43-year-old African American male presented today with c/o of cervical, bilateral upper extremities, right hip, thoracic, and lumbar spine pain. Also, patient is c/o of severe headaches and insomnia.
Patient was involved in a car accident on 09/25/2010. Patient was a restrained driver when his car was rear-ended by another car. Patient had pain right away. Patient drove to ECMC Emergency Room by himself. Patient was evaluated and released on the same day. Patient was diagnosed with cervical and lumbar spine strain and other soft tissue injury. However, patient later developed severe pain which progressively got worse. Patient seeks chiropractic care and other pain management modalities. At present, patient interested in entering official pain management program.
Pain at present 7/10 on Visual Analog Scale
At worst it is 10/10 on Visual Analog Scale
At best pain is 6/10 on Visual Analog Scale
Rest and Pain meds partially relieve pain
Prolonged more than 10 min walking, standing or sitting aggravate pain
Pain is throbbing aching and sometimes lightning sharp in nature
Pain is constant Variable in intensity.
Patient tried Lortab and Mobic with mild to moderate success.
PMH: Low back pain due to car accident in 2004. Patient was completely pain-free prior to this accident
PSH: None
Medications:

1. Lortab 10/500 one p.o. q.6 hour p.r.n.
2. Mobic 7.5 mg one p.o. q.12 hours

Allergies: NKDA
Family History: Noncontributory
Social History:
Smoking: none
ETOH use: 1- 2 beers on weekends
Illicit drugs: Occasional marijuana
Occupation: Patient is currently not working, but prior to accident worked as Buffalo news delivery man

REVIEW OF SYSTEM:

General:	Positive for Fatigue
Pulmonary:	No SOB, cough, asthma.
Cardiovascular:	No CAD, cardiac arrhythmias, HTN.

Gastrointestinal:	Minor GI discomfort after taking COX I inhibitors.
Genito-Urinary:	No urinary frequency, no incontinence.
Musculoskeletal:	Neck/midthoracic/low back pain.
Neurological:	Headaches, insomnia, highly emotional.
Endocrinological:	No history of thyroid disease or diabetes.
Hematological:	Denies anemia. No lymphadenopathy.
Skin:	No rash, edema, or dystrophic changes.
Vascular:	No evidence of vascular disease.

** All other systems were reviewed and are negative.

PHYSICAL EXAMINATION:

General:	The patient is an African American male who appears in distress related to pain and functional limitations. Mood and affect are appropriate for circumstances. Alert and oriented to place, person and time. Understands and follows all commands. No cyanosis. No clubbing. No enlarged lymph nodes.
Vital signs:	Stable. BP: 132/80, HR-77, RR-14, O2 sat 90 % on room air.
HEENT:	No facial asymmetry. Pupils are equal, about 5 mm, reactive to light and accommodation. Oral mucosal membranes are pink, moist, no oral sores.
Neck:	Neck was supple. Free of scars and lymphadenopathy.
Chest:	Clear to auscultation, no wheezing, and no rales. Vesicular breathing bilaterally.
CVS:	Heart sounds were regular, S1-S2, no murmur. No rub. No gallop.
Abdomen:	Soft, nontender, nondistended with normal bowel sounds. Liver showed no tenderness and not enlarged.
Lower extremities:	No peripheral edema. Peripheral pulses were normal on both feet. No dystrophic changes of skin and nails of both feet. No pressure sores.

- Musculoskeletal: Musculoskeletal examination demonstrated poor body mechanics with hyperkyphotic posture, rounded shoulders and straightening of the lumbosacral lordosis.
- The patient had rounded shoulders, hyperextended neck, and forward position of the head. Spurling tests (provocative test for foraminal encroaching) was positive. Occipital area was tender and sensitive for palpation. Also positive pain on palpation over Sternocleidomastoid bilaterally, Anterior, Middle and Posterior Scalenes, cervicis capitus, upper trapezius. Also positive pain on palpation over lumbar paraspinals, bilateral sacroiliac joints, bilateral gluteus maximus medius and tensor fascia lata. Also pain on palpation over the over lateral border of the sacrum bilaterally.
- The patient demonstrated decreased by functional ROM in Cervical spine and lumbar spine approximately 30 % in all planes. There were no bony misalignments and acute fractures but the patient had difficulty with squatting and toe walking and heel walking because of neck/midthoracic/low back pain.

Percussion over the spinous processes causes sharp pain over the midthoracic/ cervical/lower spine areas. There was tenderness and mild edema in the neck/thoracic/lumbosacral paraspinal muscles. The patient has significant muscle spasm and multiple trigger points in the neck/midthoracic/ lumbosacral areas. Lasegue testing (SLR) was positive, and the patient had tight hamstrings. Motor strengths were normal.

Neurological: Neurological exam demonstrated normal mental status, mild emotional labiality, mood and affect as mentioned above Swallowing is intact without evidence of swallowing disturbance. Gag reflexes were present. Cranial nerves II-XII were intact. There was no nystagmus. No facial asymmetry. Sensation to light tough, pinprick and proprioception was preserved in bilateral upper and lower extremities. Deep tendon reflexes were normal throughout the body.

ASSESSMENT:

1. MVA accident on 09/25/2010
2. Whiplash injury, cervical sprain/strain.
3. Cervical radiculopathy
4. Lumbar radiculopathy
5. Lumbar ligamentous strain
6. Cervical spine pain

All the patient's symptoms and diagnosis were casually related to the accident described in the history.

Plan:

Medications:

I will start patient on:

1. Lortab 10/500 one p.o. q.6 hours p.r.n. #56 prescribed
2. Flexeril 10 mg one p.o. q.8 hours p.r.n. #45 prescribed

I discussed at length with patient different strategies on how to manage patient's pain and a trial of Subosipital Nerve block, Facet Blocks, intra-ligamentous injections and Narcotic Pain Management regiment will be tried first. I did provide patient with booklet on intra-ligamentous injections. I also counseled patient on statistics, indications, and contraindications of intra-ligamentous injections. Patient would like to review the handout at home and then make a decision. Patient was extensively counseled.
Also The Opioid Pain Management Agreement was signed by the Patient.
Baseline urine toxicology screen was obtained from the patient. Please see table below for preliminary results:

Drug Name	Negative	Positive	Consistency
1.Cocaine	X		Consistent

2. Marijuana		X	Inconsistent
3. Opiates	X		Consistent
4. Amphetamines	X		Consistent
5. Phencyclidine	X		Consistent
6. Methamphetamine	X		Consistent
8. Barbiturates	X		Consistent
9. Benzodiazepines	X		Consistent
10. Methadone	X		Consistent
11. Tricyclic antidepressants	X		Consistent
12. Oxycodone	X		Consistent
Data collection	07/14/2011		

Inconsistent urine toxicology screen positive for marijuana was discussed with patient. Patient was advised about using illicit substances while in pain management program. Patient promised to abstain from any illicit substances. I counseled patient on importance of compliance with State and Federal regulation concerning pain management program. Patient agreed to cooperate and follow the rules of the program.
Thank you for the consultation request and for the opportunity to participate in the patient's care. I spent 60 minutes with the patient. CPT code for this encounter is 99244 and CPT code for urine toxicology screen is 80101 x9 units Please process in accordance with New York state fee schedule.

MD

Date: 07/14/2011

Mikhail Strutsovskiy M.D.

CC: